1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death ... any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06195

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06190

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐ Month	Day	Year	2b. HOUR
	HARRY	DAVID	AIRESMAN	MAY	3	1969	7 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	White	Nov 19,1893	75 YRS.					MAY	3	1969	7 P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penna	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	MEMORIAL HOSPITAL -DOA	Retired Employee- U.S. Government.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland Rt 1	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank		Aiersman	Emma		Ash

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		210-05-7381	Mrs. Catherine Airesman	Route #1 Bx 653 Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

22b. DATE SIGNED: MAY 3, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/6/69	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service.	Cumberland, Md 21502	MAY 8 1969	Charles Judge

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06196

06191

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Harry	Irvin	Alexander	May	29	1969	4:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	Aug. 7, 1911	57 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Virginia	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	215 E. Oldtown Rd.	Salesman	Shoe Store

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	215 E. Oldtown Road

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
William Franklin Alexander	Ina May Laurent

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
National Guard		Miss Dieatra Alexander, Va., Daughter

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Peripheral vasular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-24-50, 19 50, to 5-29, 19 69, that (I) (we) last saw the deceased alive on 5-19, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ralph W. Ballin M.D.	M.D.	☒	☐	☐	June 2, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Ralph W. Ballin, M.D.	62 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 2, 1969	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 3 1969	Clerk, Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (R)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06197 07698

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROSA	I	AMBROSE	5 30 69	7:20A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	9-5-91	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	U.S.A.	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.	MORGAN	PAW PAW	YES [X] NO [ ]	c/o Postmaster

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		WAGONER	SARAH		MISLAGLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis Marked
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 5-20- 19 69, to 5-30- 19 69, that (I) ~~(we)~~ last saw the deceased alive on 5-29- 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE W. F. Williams DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 5-31-69

22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS — 22e. ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	June 1, 1969	Woodrow Cemetery	Paw Paw, Morgan W. Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Johnson Funeral Home	Berkeley Springs, W. Va.	JUN 11 1969	Wanda Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

06198

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME-PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Clara; Middle: ; Last: Beery				2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: May 30 1969	2b. HOUR: 3:30 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: July 22, 1880	6. AGE (In years last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.)	2c. DATE PRONOUNCED DEAD Month May Day 30 Year 1969	2d. HOUR: 3:30 P.M.
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 28 Penna . Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 28 Pennsylvania Ave.	
14. FATHER'S NAME First: Henry; Middle: W.; Last: Haines		15. MOTHER'S MAIDEN NAME First: Elizabeth; Middle: ; Last: Easter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Mr. Russell Beery, Cumberland, Md. Son			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Rt.9, Cumberland, Md.

22b. DATE SIGNED: May 30, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 2, 1969	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE: JUN 3 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15ME (5) 10M REV. 1/68

06199

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06193

1. DECEASED-NAME (Type or print) First: MARION	Middle: NMI	Last: BOND	2a. DATE OF DEATH Month: 5 Day: 19 Year: 69 — 2b. HOUR: 11:25 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 01 16 18	6. AGE (In years last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY CO., Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 88 BRADDOCK ST.
14. FATHER'S NAME First: GRIFFITH	Middle:	Last: HUGHES	15. MOTHER'S MAIDEN NAME First: (REES) ANN — Middle: — Last: HUGHES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-4051	17. INFORMANT: PATIENT'S HOSPITAL CHART	Address: 900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia

DUE TO, OR AS A CONSEQUENCE OF (b): Renal failure

DUE TO, OR AS A CONSEQUENCE OF (c): Malignant Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 400.3

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Subarachnoid haemorrhage

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clarence J. Vincent M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]			22c. DATE SIGNED: 5/23/69
22d. PHYSICIAN'S NAME (Type): CLARENCE J. VINCENT, M. D.		22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: MAY 22, 1969	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town): FROSTBURG, MD.	(County) (State)
24. FUNERAL DIRECTOR: BURST FUNERAL HOME	ADDRESS: 57 FROST AVE. FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE: MAY 26 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 13 MD 45M 1/69

13

06200

Item6 Film 12 5/16/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Inez	Middle: I.	Last: Bradfield	2a. DATE OF DEATH Month 5 Day 7 Year 69	4:50 P. M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: 9/10/95	6. AGE (In years last birthday): 73 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10 CITY OR TOWN OF DEATH: Cumberland, Maryland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived. If inst'l pt. on Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 708 Yale Street	
14 FATHER'S NAME First: George	Middle	Last: Stine	15 MOTHER'S MAIDEN NAME First: Ella	Middle	Last: Brill
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 217-14-4929-A	17 INFORMANT: P. O. Box 599 Allegany County Infirmary	Address: Cumberland, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Cerebral Embolism — approx. 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4121

DUE TO, OR AS A CONSEQUENCE OF (b): Chr. ASHD & P.H.D? Hypertension — many years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — many years

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chr. Uremic Syndrome.

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from April 15, 19 68, to May 7, 19 69, that (I) (we) last saw the deceased alive on May 7, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: John A. Topper MD	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒	22c DATE SIGNED: 5-8-69	
22d PHYSICIAN'S NAME (Type): John A. Topper MD	22e ADDRESS: Memorial Hospital, Cumberland, Maryland		

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: MAY 10, 1969	23c NAME OF CEMETERY OR CREMATORY: SUNSET MEM. PARK	23d LOCATION (City or Town): CUMBERLAND, MD.	(County) (State)
24 FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a REC'D BY REGISTRAR: MAY 13 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 5M 1-66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death

06201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First: Milo	Middle: Albertas	Last: Brewer	2a DATE KNOWN OF DEATH ESTIMATED: MAY 16, 1969	2b HOUR: 10:20 AM			
3 SEX: M	4 RACE: W	5 DATE OF BIRTH: Nov. 11, 1900	6 AGE (in years last birthday): 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c DATE PRONOUNCED DEAD: May 16, 1969	2d HOUR: 10:20 AM
7a BIRTHPLACE (State or foreign country): Pa.	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md				
10 CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Contractor	12b KIND OF BUSINESS OR INDUSTRY: Self Employed				
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE: Md.	13b. COUNTY: Garrett	13c CITY OR TOWN: Bittinger	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER			
14 FATHER'S NAME First: Labanna	Middle	Last: Brewer	15 MOTHER'S MAIDEN NAME First: Louisa	Middle	Last: (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Mrs. Nola Brewer, Bittinger, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: MAY 16, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/19/69	23c NAME OF CEMETERY OR CREMATORY: Bittinger Cemetery	23d LOCATION (City or Town) (County) (State): Bittinger, Garrett, Md.	
24 FUNERAL DIRECTOR: Ruth Newman	ADDRESS: Grantsville, Md.	25a RECD BY REGISTRAR DATE: MAY 23 1969	25b REGISTRAR'S SIGNATURE: Florida Judge	

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06202 — 06196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: GEORGE	Middle: W.	Last: CARDER	2a. DATE OF DEATH Month: 5 Day: 12 Year: 69	2b. HOUR: 11:27 A.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-24-1893	6. AGE (In years last birthday): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): CEMENT HOUSE WORKER	12b. KIND OF BUSINESS OR INDUSTRY: Kelly Springfield			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. #3, BEDFORD ROAD,		
14. FATHER'S NAME First: JAMES * [illegible]	Middle	Last: CARDER	15. MOTHER'S MAIDEN NAME First: NANCY	Middle: JEANETTA	Last: ROBINSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): WW 1	16b. SOCIAL SECURITY NO.: 215-10-1228	17. INFORMANT: MEMORIAL HOSPITAL-CUMBERLAND, MD.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Emphysema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO, OR AS A CONSEQUENCE OF (b): —

DUE TO, OR AS A CONSEQUENCE OF (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 412X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerosis

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): —	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): —	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: [illegible]	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/26/69 19___, to 5/12/69 19___, that (I) (saw) last saw the deceased alive on 5/12/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. J. Williams DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐
22c. DATE SIGNED: 5/13/69			
22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS	22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 16, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cath. Cem.	23d. LOCATION (City or Town): Frostburg, M	(County): Alleg	(State): Md
24. FUNERAL DIRECTOR: John J. Hafer, Jr.,	ADDRESS: 230 Baltimore Ave. Cumberland,	25a. RECD BY REGISTRAR DATE: MAY 15 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

VR A1
45M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06203

CERTIFICATE OF DEATH

06197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: E.	Last: CARROLL	2a. DATE OF DEATH: MAY Month 20 Day, 1969	2b. HOUR: 3:10 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-12-1910	6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: ALLEGANY		Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 13 LAING AVE.	
14. FATHER'S NAME First: SAMUEL	Middle:	Last: ODEN	15. MOTHER'S MAIDEN NAME First: SADIE	Middle:	Last: THOMPSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL,	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48hrs

4122

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): Hypertensive Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 1954, 19___, to May, 19 69, that (I) (☒) last saw the deceased alive on 5-21-69 19___, and that in (my) (☒) opinion death occurred on the date and hour and from the causes stated above, (I) (~~attended~~ did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED: 5-22-69

22d. PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT

22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION (Specify): Burial	23b. DATE: May 24, 1969	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: MAY 28 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06204

06198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4-68 45M TX69

1. DECEASED NAME (Type or print)	First: EARL	Middle:	Last: COOPER	2a. DATE OF DEATH: Month 5 Day 7 Year 69	2b. HOUR: 4:50A	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-10-06	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): W. VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): DISABLED - Orderly	12b. KIND OF BUSINESS OR INDUSTRY: State Hospita			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 2, WILLIAMS RD.		
14. FATHER'S NAME First: JOHN	Middle:	Last: COOPER	15. MOTHER'S MAIDEN NAME First: MOLLIE	Middle:	Last: COOPER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): Peace Time	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Emphysema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492 X

DUE TO, OR AS A CONSEQUENCE OF: —

(b): —

DUE TO, OR AS A CONSEQUENCE OF: —

(c): —

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18): —	
21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.): —	21f. LOCATION Street or R.F.D. No.: — City or Town: Cumberland	County: Allegany	State: Md.

22a. I certify that (I) (this hospital) attended the deceased from 4/7/67, 19__, to 5/7/69, 19__, that (I) (we) last saw the deceased alive on 5/6/69, 19__, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: R. J. Williams M.D. DEGREE — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 5/8/69

22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 9, 1969	23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery	23d. LOCATION (City or Town): Cumberland, Al	(County): legany, (State): Md.
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: MAY 12 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

06205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: BELMONT	Middle:	Last: CRABTREE	2a. DATE OF DEATH Month: MAY Day: 22, Year: 1969	2b HOUR 9:17 P	
3 SEX: MALE	4 RACE: WHITE	5. DATE OF BIRTH: 9-16-1912	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a BIRTHPLACE (State or foreign country): W. Va.	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED ☐ NEVER MARR ED ☐ WIDOWED ☐ D VORCED ☒	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired): UNEMPLOYED Farm Helper	12b KIND OF BUSINESS OR INDUSTRY: Farm		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c CITY OR TOWN: RAWLINGS	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. 3	
14 FATHER'S NAME First: JAMES	Middle:	Last: CRABTREE	15 MOTHER'S MAIDEN NAME First: RACHEL	Middle:	Last: KERNS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSPITAL,	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rocky Mountain Spotted Fever — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
0820
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from May 13, 1969, to May 22, 1969, that (I) (we) last saw the deceased alive on May 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c DATE SIGNED: 5-25-69	
22d PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT	22e ADDRESS: CUMBERLAND, MD.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 25,1969	23c NAME OF CEMETERY OR CREMATORY: Kerns Cemetery	23d LOCATION (City or Town) (County) (State): Near Oldtown, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a RECD BY REGISTRAR DATE: MAY 27 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR AT 45M 1-69

1

06206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06200

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Cloud	S.	Darr	May 25, 1969	8:10 A.M. P.M.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	Colored	6/15/1876	92 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	U. S. A.	WIDOWED [X]	Allegany County Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Retired:Chauffeur	Chauffeur

13a USUAL RESIDENCE (Where deceased lived, if institution) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	336 Central Avenue

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Darr	Ellen		Washington

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	Address
	165-09-3909	P.O.Box 599, Allegany County Infirmary records.	Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROX MATE INTERVAL, BETWEEN ONSET AND DEATH: 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 4 0 9

DUE TO, OR AS A CONSEQUENCE OF (b) Gen. arteriosclerosis — 1 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from Jan. 8, 19 64 to May 25, 19 69, that (I) (we) last saw the deceased alive on May 24, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	22c DATE SIGNED
George M. Simons	ATTENDING PHYS [X] MED DIRECTOR [X] STAFF PHYS [X]	5/26/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
George M. Simons	Memorial Hospital, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/28/69	Rose Hill Cem.	Cumberland Allegany Md

24 FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md	MAY 28 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (01) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06207 — 06201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First: DAWSON Middle: CHARLES Last: LEO		2a DATE OF DEATH: MAY Month 11 Day 1969	2b HOUR: 5:05A
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 6-28-1910	6 AGE (In years last Birthday): 58 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min)
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY Md.
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired):	12b KIND OF BUSINESS OR INDUSTRY: RAILROAD
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES [ ] NO [ ]	13e STREET AND NUMBER: WRIGHT AVE. BOWLING GREEN
14 FATHER'S NAME First: HARRY Middle: Last: DAWSON		15 MOTHER'S MAIDEN NAME First: MAY Middle: ELIZABETH Last: MC KENZIE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 216-09-7100	17 INFORMANT Address: MEMORIAL HOSP., CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROX. INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Subarachnoid Haemorrhage

4300

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE: Clarence J. Vincent M.D. DEGREE	ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: May 16, 1969	
22d PHYSICIAN'S NAME (Type): Clarence J. Vincent, M.D.	22e ADDRESS: 912 Seton Drive, Cumberland, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 14, 1969	23c NAME OF CEMETERY OR CREMATORY: Philos Cem	23d LOCATION (City or Town) (County) (State): Westernport Allegany Md.
24 FUNERAL DIRECTOR: E. L. Boal ADDRESS: Westernport, Md.	25a. REC'D BY REG'STRAR DATE: MAY 19 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (10-68) 45M - 1-69

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06208

Items13&23 FilmCh13 6/16/69 kk

CERTIFICATE OF DEATH

07713

1. DECEASED-NAME (Type or print) First: BABY BOY	Middle:	Last: DURST	2a. DATE OF DEATH: 5 Month 25 Day 69 Year	2b. HOUR: 3:00P M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-25-69	6. AGE (In years last birthday): NB - YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS: 14 / MIN.
7a. BIRTHPLACE (State or foreign country): MEYERSDALE, PA.	7b. CITIZEN OF WHAT COUNTRY? U..S. A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY COUNTY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Garrett	13c. CITY OR TOWN: Grantsville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D. #2	
14. FATHER'S NAME First: CARL	Middle:	Last: DURST	15. MOTHER'S MAIDEN NAME First: SHIRLEY	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSP.	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b): Immaturity

DUE TO, OR AS A CONSEQUENCE OF

(c): Onset of labor @ 26-28 wks -

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 ___, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert J. Dawson M.D.	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐
22c. DATE SIGNED: 6/6/69				
22d. PHYSICIAN'S NAME (Type): DR. ROBERT J. DAWSON	22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 5/28/69	23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital	23d. LOCATION (City or Town) (County) (State): Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE: JUN 10 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06209 — 06202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: CLYDE Middle: I. Last: DYE	2a. DATE OF DEATH Month: 5-29- Day: Year: 1969	2b. HOUR 8:20 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-20-21	6. AGE (In years last birthday): 48 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life. Never retired): UNEMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: WESTERNPORT	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 133 FRONT ST.,
14. FATHER'S NAME First: GEORGE Middle: Last: DYE	15. MOTHER'S MAIDEN NAME First: ESTHER Middle: Last: MC MANNIS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 214-16-2617	17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coma
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5719
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from 5-24, 1969 to 5-29, 1969, that (I) (we) last saw the deceased alive on 5-24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William P. James DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]		22c. DATE SIGNED: 6-3-69
22d. PHYSICIAN'S NAME (Type): DR. W. P. JAMES	22e. ADDRESS: CUMBERLAND, MD.	

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/1/69	23c. NAME OF CEMETERY OR CREMATORY: Bloomington	23d. LOCATION (City or Town): Bloomington, (County): Garrett (State): Md.	
24. FUNERAL DIRECTOR: E. L. Beal	ADDRESS: Westernport, Md.	25a. RECD. BY REGISTRAR DATE: JUN 9 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A1
45M - 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06210

06203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: CHARLES	Middle: Rexford	Last: ELLIS	2a. DATE OF DEATH Month: 05 Day: 28 Year: 69
2b. HOUR: 6:05 P.M.			
3 SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 09-19-25	6. AGE (In years last birthday): 43 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY COUNTY, Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MARYLAND WORKSHOP FOR (Supervisor)	12b KIND OF BUSINESS OR INDUSTRY: THE BLIND
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: 405 MC MULLEN HIGHWAY
14 FATHER'S NAME First: CHARLES	Middle: A.	Last: ELLIS	15 MOTHER'S MAIDEN NAME First: (STEWART) GLADYS	Middle	Last: ELLIS
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 236-54-0961	17 INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., Address MD. 21502	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Generalized Peritonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO, OR AS A CONSEQUENCE OF

(b): Appendicitis — 2 1/2 wks

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 400

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 5-13-69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Appendicitis	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)

21f LOCATION Street or R.F.D. No | City or Town | County | State

22a I certify that (I) (this hospital) attended the deceased from 13 May, 1969, to 28 May 1969, that (I) (we) last saw the deceased alive on 28 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b SIGNATURE: F.W. Miltenberger M.D. DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c. DATE SIGNED: 5/30/69

22d. PHYSICIAN'S NAME (Type): F.W. MILTENBERGER, M.D.

22e. ADDRESS: 122 S. CENTRE ST., CUMB., MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/31/69	23c NAME OF CEMETERY OR CREMATORY: Cunningham Memorial Park	23d LOCATION (City or Town): St. Albans	(County): Kanawha, (State): W. Va.

24 FUNERAL DIRECTOR: H. Wayne George ADDRESS: MD. 21502

GEORGE FUNERAL HOME, 202 GREENE ST., CUMB.,

25a. RECD BY REGISTRAR DATE: JUN 2 1969

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06211 06204

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: RAYMOND	Middle: W.	Last: FANNON	2a. DATE OF DEATH: 5 Month 4 Day 69 Year
2b. HOUR: 4:50 PM			
3 SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11/03/07	6. AGE (In years last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY CO. Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP	12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired): SALESMAN-HEINRICH'S	12b KIND OF BUSINESS OR INDUSTRY: MENSSTORE
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: MT. SAVAGE	13d. INSIDE CITY LIM TS? YES [ ] NO [X]
13e STREET AND NUMBER: P.O. BOX 382			
14 FATHER S NAME First: WILLIAM	Middle	Last: FANNON	15 MOTHER S MAIDEN NAME First: CARNEY Middle: MARY Last: FANNON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-01-0138	17 INFORMANT: PATIENT'S HOSPITAL CHART-	Address: 900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PNEUMONIA BILATERAL	5 WKS
DUE TO, OR AS A CONSEQUENCE OF (b)	ACUTE PERICARDITIS WITH ATRIAL FIBRILLATION	3 WKS
DUE TO, OR AS A CONSEQUENCE OF (c)	CONGESTIVE HEART FAILURE	3 WKS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GENERALIZED RHEUMATOID ARTHRITIS, SEVERE

19a DATE OF OPERATION: NONE	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [#] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): NONE
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC): NONE	21f. LOCATION Street or R F D No / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 4-17-69, 19____, to 5-4-69, 19____, that (I) (we) last saw the deceased alive on 5-4-69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: James P. Hallinan MD — DEGREE: ATTENDING PHYS [#] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 5-6-69

22d. PHYSICIAN'S NAME (Type): DR. JAMES P. HALLINAN — 22e. ADDRESS: 140 BEDFORD ST., CUMBERLAND, MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: MAY 7, 1969	23c NAME OF CEMETERY OR CREMATORY: ST. PATRICK'S CEMETERY	23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR.,	ADDRESS: FROSTBURG, MD. 21532	25a REC'D BY REGISTRAR DATE: MAY 9 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

1/6

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06212

06205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
MARGARET	E.	FRADISKA	MAY	12	1969	5:05 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
FEMALE	WHITE	5-28-90	78 YRS.				

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	Cumberland	YES ☑ NO ☐	639 SHRIVER AVENUE

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		HORCHLER	ANNA		WERNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	220-46-8895	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

DUE TO, OR AS A CONSEQUENCE OF

(b) Diebetic Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diebetes Mellitus

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1968, 19___, to May, 19 69, that (I) (we) last saw the deceased alive on May 12,1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) ~~visited~~ (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
					5-14-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
G.Overton Himmelwright, M.D.	133 Va.Ave.,Cumberland, Md.

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/17/69	Hillcrest Burial Pk	Cumberland Allegany Md

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md	MAY 15 1969	

VR A15 M
45M X69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

06213 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06206

1 DECEASED-NAME (Type or Print) First: [illegible] Middle: C. Last: [illegible]				2a DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: MAY 29, 1969	2b HOUR: 11p M
3. SEX: [illegible]	4. RACE: White	5 DATE OF BIRTH: Jan. 3, 1[illegible]	6 AGE (In years last birthday): 73 YRS; IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year 19: MAY 29, 1969	2d. HOUR: 11p M
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH: Alle[illegible] Md	
10 CITY OR TOWN OF DEATH: [illegible]	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL-DOA			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired): [illegible]	12b KIND OF BUSINESS OR INDUSTRY: [illegible]
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: [illegible]	13b COUNTY: [illegible]	13c CITY OR TOWN: [illegible]	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: [illegible]	
14 FATHER'S NAME First Middle Last: Charles [illegible]		15. MOTHER'S MAIDEN NAME First Middle Last: Mary [illegible]			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 21[illegible]	17. INFORMANT ADDRESS: [illegible]		

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 29, 1969

ADDRESS (Street, city): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: [illegible]	23c. NAME OF CEMETERY OR CREMATORY: [illegible]	23d. LOCATION (City or Town) [illegible] (County) (State)	
24 FUNERAL DIRECTOR: [illegible]	ADDRESS: [illegible]	25a RECD BY REG'STRAR DATE: JUN 3 1969	25b REG'STRAR'S SIGNATURE: Charles Judge	

06214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item6 Film6413 5/29/69 kk

06207

1. DECEASED NAME (Type or print)	First: ESTON	Middle: I.	Last: FULTZ	2a. DATE OF DEATH Month: MAY	Day: 17	Year: 1969	2b. HOUR: 5:15PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 6, 1889	6. AGE (In years last birthday): 79 80 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HSOPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired):	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: ROUTE #5, BOX 87 A			
14. FATHER'S NAME First: JOHN	Middle:	Last: FULTZ	15. MOTHER'S MAIDEN NAME First: JANIE	Middle:	Last: SNYDER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown): YES (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-7880	17. INFORMANT: HOSPITAL RECORD	Address: 900 SETON DRIVE, CUMB., MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Decompensation — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF
(b): Pulmonary Emphysema and — —
DUE TO, OR AS A CONSEQUENCE OF
(c): Chronic Lung Disease — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma Pulmonary Tb Coronary Occlusion

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/22, 1969 to 5/17, 1969, that (I) (we) last saw the deceased alive on 5/17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J.A. Pagan — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 5/18/69

22d. PHYSICIAN'S NAME (Type): J.A. PAGAN, M.D. — 22e. ADDRESS: 1068 NATIONAL HWY., LA VALE, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/20/69	23c. NAME OF CEMETERY OR CREMATORY: Fultz Cemetery	23d. LOCATION (City or Town) (County) (State): Keyser, Hardy, W. Va.	
24. FUNERAL DIRECTOR: THRUSH FUNERAL HOME	ADDRESS: MOOREFIELD, W. VA.	25a. RECD BY REGISTRAR DATE: MAY 23 1969	25b. REGISTRAR'S SIGNATURE: Dorothy Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as ■ burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M REV. 1/68

06215

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06208

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED [X] Month	Day	Year	2b HOUR AM/PM
Herman	Simon	Greise	5	24	1969	8:15 PM
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR AM/PM
Male	White	Dec 27, 1901	67 YRS			5	24	1969	8:15 PM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp ta give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL--DOA	Meat Packing Business	

13a USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [ ] NO [X]	Rt #3- Box 508

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	C	Greise	Catherine		Borgman

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	215-36-8753	Mrs. Frances Greise	Route #3 Box 508 Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: May 24, 1969

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/27/69	S/S. Peter & Paul Cemetery	Cumberland Allegany Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md	21502	MAY 27 1969	Charles Yeager

1

06216

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MARY	Middle: D.	Last: HADLEY	2a. DATE OF DEATH: 5 Month 21 Day 69 Year	2b. HOUR: 2:50PM		
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 5 31 99	6. AGE (In years last birthday): 69 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md			
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): *** Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 514 BEDFORD STREET		
14. FATHER'S NAME First: DAVID	Middle	Last: HOLMES	15. MOTHER'S MAIDEN NAME First: (DOUGLAS) JANE	Middle	Last: HOLMES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 213 18 2497D	17. INFORMANT: PATIENT'S HOSPITAL CHART	Address: 900 SETON DRIVE CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	12 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertensive cardiovascular disease	5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute myocardial failure	12 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized osteoarthritis and arteriosclerosis

19a. DATE OF OPERATION: none	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑ ##	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): none	
21d. INJURY OCCURRED White at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from March 20, 19 62, to May 21, 19 69, that (I) (we) last saw the deceased alive on May 21, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I), (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS # ☐ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 5-22-69

22d. PHYSICIAN'S NAME (Type): DR. J. P. HALLINAN — 22e. ADDRESS: 140 BEDFORD ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/24/69	Oak Hill Cemetery	Lonoconing Allegany Maryland

24. FUNERAL DIRECTOR: Merritt — ADDRESS: SILCOX FUNERAL HOME. Cumberland, Maryland 21502

25a. RECD BY REGISTRAR DATE: MAY 26 1969 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 45M 1-69

1

06217

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06210

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
WILLIAM	B.	HARVEY	MAY	18	1969	8 43/4 M

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
MALE	WHITE	MAY 8, 1876	93 YRS.				

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
TENNESSEE	U.S.A.		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	RETIRED PRINTER - M&B	PRINTING CO.

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☒ NO ☐	

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JACKSON		HARVEY	NARCISSIS		KILLINGSWORTH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
NO	410-01-8926	THOS. A. HARVEY, MT. SAVAGE, MD. 21545

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	1 week -
DUE TO, OR AS A CONSEQUENCE OF (b)	Athe V D.	7 years -
DUE TO, OR AS A CONSEQUENCE OF (c)	Silicosis & emphysema	years.

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 5/15, 1969, to 5/18, 1969, that (I) (~~we~~) last saw the deceased alive on 5/18 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John B. Davis	MD				5/18/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN B. DAVIS, M. D.	5 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	MAY 21, 1969	WOODLAWN CEMETERY	NASHVILLE, TENN.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	MAY 22 1969	Charles Yuga

VR A15 (4)
30M REV 1/68

13

06218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: FLORENCE	Middle: LEONA	Last: HENRY	2a. DATE OF DEATH: 5 Month 11 Day 69 Year	2b. HOUR: 10:30 A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 03 08 01	6. AGE (In years last birthday): 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): NONE Former Packer	12b. KIND OF BUSINESS OR INDUSTRY: Amunition		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: RIDGELEY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 45 POTOMAC STREET	
14. FATHER'S NAME First: ALBERT	Middle: L.	Last: DECKER	15. MOTHER'S MAIDEN NAME First: (KIGHT) ESTELLA	Middle: M.	Last: DECKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215 20 6912	17. INFORMANT: PATIENT'S HOSPITAL CHART	Address: 900 SETON DRIVE CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Hypertensive CVA

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): Old Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4122

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from May 1, 1969, to May 11, 1969, that (I) (we) last saw the deceased alive on May 11, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B. M. Schindler	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 5/12/69	
22d. PHYSICIAN'S NAME (Type): DR. B. M. SCHINDLER	22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/14/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d. LOCATION (City or Town): Cumberland, (County): Allegany (State): Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: GEORGE'S FUNERAL HOME Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: MAY 15 1969	25b. REGISTRAR'S SIGNATURE	

VR A13
45M 68

13

06219

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-3-1
45M - 68

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
HENRY	NMI	HITCHINS	5	7	69	4:50 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	3/20/77	92 YRS				

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RUBBER	RUBBER

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG		ROUTE 1 -BOX 150

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
James	H.	Hitchins	STEVENS	MARY ANN	HITCHINS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address
NO	217 10 6491	SACRED HEART HOSPITAL	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pneumonia, Bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarction, Left — 1 month

DUE TO, OR AS A CONSEQUENCE OF (c) Right hemiparesis — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerosis Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While ☐ at work Not while ☐ at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/7, 1969, to 5/7, 1969, that (I) (we) last saw the deceased alive on 4/7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
[signature]	MD	☒	☐	☐	5/8/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. G. WEISMAN	59 GREENE STREET -CUMBERLAND, MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	May 10, 1969	Frostburg Memorial Park	Frostburg	Alleg.	Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
DURST FUNERAL HOME -FROSTBURG, MARYLAND	57 FROST AVE.	MAY 12 1969	[signature]

4 1

MARYLAND STATE DEPARTMENT OF HEALTH

06220 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT. 11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First: George	Middle: Walter	Last: Horchler	2a DATE KNOWN OF DEATH ESTIMATED ☐	Month: May	Day: 14	Year: 1969
2b HOUR	8:30 A M						
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	M.N
Male	White	May 30, 1901	67 YRS				
2c. DATE PRONOUNCED DEAD	Month: May	Day: 14	Year: 1969	2d HOUR	9 A M		
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH	Allegany Md.	
10. CITY OR TOWN OF DEATH	Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Hazen Road	12a. USUAL OCCUPATION (Kind of work done for most of working life, even if retired.)	Retired Fireman	12b KIND OF BUSINESS OR INDUSTRY	Brewing Co.
13a USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE	Md.	13b COUNTY	Allegany	13c. CITY OR TOWN	Cumberland	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: Hazen Road
14 FATHER'S NAME First	Middle	Last: Frederick Horchler	15. MOTHER'S MAIDEN NAME First	Middle	Last: Mary Amanda Gerdeman		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS: Mrs. Lottie Horchler, Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic MD

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Rt.9, Cumberland

22b DATE SIGNED: May 14, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 16, 1969	Sunset Memorial Park	Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli,	Cumberland, Md.	MAY 19 1969	Charles Judge

VR A15ME (5) 10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06221 — 06214

1 DECEASED-NAME (Type or Print)	First: Charles	Middle: P.	Last: Hoyle	2a DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month: May Day: 30 Year: 1969	2b HOUR: 7:15 P.M.
3 SEX: Male	4. RACE: White	5 DATE OF BIRTH: Oct. 31, 1897	6 AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: May Day: 30 Year: 1969	2d HOUR: 7:15 P.M.
7a. BIRTHPLACE (State or foreign country): W. Va.	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 219 Utah Ave.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Trackman	12b KIND OF BUSINESS OR INDUSTRY: Railroad		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 219 Utah Ave.	
14. FATHER'S NAME First Middle Last: William Hoyle		15 MOTHER'S MAIDEN NAME First Middle Last: Virginia Miller			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes	(If yes give war or dates of service): War I	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS: Mrs. Stella Hoyle, Cumberland, Md. Wife		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROX. INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

+109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county): Rt. 9, Cumberland, Md

22b. DATE SIGNED: May 30, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 2, 1969	23c NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.		25a REC'D BY REG STRAR DATE: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06222 — 06215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: ROBERT	Middle: A.	Last: JOHNSON	2a. DATE OF DEATH: Month 5 Day 2 Year 69	2b. HOUR: 1:15 A	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 9-23-84	6. AGE (In years last birthday): 84 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): CONN.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARRYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 60 BOONE ST.		
14. FATHER'S NAME First: JOHN	Middle: O.	Last: JOHNSON	15. MOTHER'S MAIDEN NAME First: CAROLINA	Middle: C.	Last: GUSTAFSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 705-07-6797	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 mm

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

DUE TO, OR AS A CONSEQUENCE OF (b): Ventricular Tachycardia

DUE TO, OR AS A CONSEQUENCE OF (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 4/24/69 19___, to 5/2/69 19___, that (I) (we) last saw the deceased alive on 5/2/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 5/7/69

22d. PHYSICIAN'S NAME (Type): DR. ~~[illegible]~~ Richard Williams, MD — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May, 4, 1969	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. RECD BY REGISTRAR DATE: MAY 6 1969	25b. REGISTRAR'S SIGNATURE: Melinda Judge	

VR A15(14) 45M 1-69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

06223

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06216

1 DECEASED-NAME (Type or Print) First: Kenneth	Middle: Leroy	Last: Keefer	2a DATE KNOWN OF DEATH ☐ ESTIMATED ☒ Month Day Year: May 4, 1969	2b HOUR: 11:35a.m.				
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: June 10, 1937	6 AGE (in years last birthday): 31 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: May 4, 1969	2d HOUR: 11:35a.m.	
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md					
10 CITY OR TOWN OF DEATH: Route 51	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital--DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer	12b KIND OF BUSINESS OR INDUSTRY: Iron Works					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 811 Maryland Ave.				
14 FATHER'S NAME First: Leroy	Middle: M.	Last: Keefer	15 MOTHER'S MAIDEN NAME First: Elinor	Middle: Valentine	Last:			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS: Mr. Leroy M. Keefer, Cumberland, Md, Father						

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Crushed Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): (Passenger in 2 car collision)

DUE TO, OR AS A CONSEQUENCE OF (c):

8121

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH: about	21b TIME OF INJURY Month, Day Year HOUR A.M.: 11:00 May 4, 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Passenger in 2 car auto accident
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Route # 51	21f LOCATION Street or R.F.D. No / City or Town / County / State: 900 yds. west of Mexico farms rd. Alleg. Md.

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 4, 1969

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 7, 1969	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: MAY 6 1969	25b REGISTRAR'S SIGNATURE: Hilliard E. Judge	

1

06224

Item4 Film G413 6/5/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: JOHN	Middle: LEE	Last: KELLY	2a. DATE OF DEATH Month: MAY Day: 28, Year: 1969
2b. HOUR OF DEATH: P.M. 6:15			
3. SEX: MALE	4. RACE: ~~WHITE~~ White	5. DATE OF BIRTH: MARCH 4, 1892	6. AGE (In years last birthday): 77 YRS. If under 1 year: Months / Days. If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (State or foreign country): ECKHART, MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 89 W. MAIN STREET	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MINER	12b. KIND OF BUSINESS OR INDUSTRY: COAL
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 89 W. MAIN STREET			
14. FATHER'S NAME First: FRANCIS	Middle	Last: KELLY	15. MOTHER'S MAIDEN NAME First: CHRISTIANA	Middle	ECKART
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO	(If yes give war or dates of service): N.A.	16b. SOCIAL SECURITY NO: 214-01-3774	17. INFORMANT: MRS. J. LEE KELLY, 89 W. MAIN STREET, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): arterio-sclerotic heart disease — Approximate interval between onset and death: —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arterio-sclerosis — —

DUE TO, OR AS A CONSEQUENCE OF (c): anthracosis - silicosis — —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): senility

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 5/1, 1965, to 5-28, 1969, that (I) (~~we~~) last saw the deceased alive on 5-28 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the couses stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: H. C. Diehl, M.D. DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c. DATE SIGNED: 5/30/69.

22d. PHYSICIAN'S NAME (Type): H. C. DIEHL, MD.

22e. ADDRESS: 39 W. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION REMOVAL (Specify): BURIAL	23b. DATE: 5/31/69	23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State): FROSTBURG, ALLEGANY, MD.	
24a. FUNERAL DIRECTOR: MARIBOU M. SOWERS, HAFER-SOWERS FUNERAL HOME	ADDRESS: 60 W. MAIN, FROSTBURG	25a. RECD BY REGISTRAR DATE: JUN 2 1969	25b. REGISTRAR'S SIGNATURE: Wilma A. Judge	

VR A15-74
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06225 06218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15
45M - 1/69

1. DECEASED-NAME (Type or print) First: IONA	Middle:	Last: KEMP	2a. DATE OF DEATH Month: MAY Day: 30 Year: 1969	2b. HOUR:		
3 SEX: FEMALE	4. RACE: WHITE	5 DATE OF BIRTH: FEBRUARY 18, 1908	6. AGE (In years last birthday): 61 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md			
10 CITY OR TOWN OF DEATH: FROSTBURG	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): COOK	12b KIND OF BUSINESS OR INDUSTRY: COUNTRY CLUB			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: FROSTBURG	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 201 WELSH HILL		
14 FATHER'S NAME First: CLARENCE	Middle:	Last: CHANEY	15. MOTHER'S MAIDEN NAME First: IDA	Middle:	Last: GARLITZ	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 212-24-0634	17 INFORMANT: RAYMOND F. KEMP,	Address: CHEVY CHASE, MD			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) ACUTE BRAIN SYNDROME — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 17

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CIRCULATORY DISTURBANCE

DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS — 8 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

DIABETES MELLITUS

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d INJURY OCCURRED While ☐ Not while ☐ at work / at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a **I certify** that (I) (this hospital) attended the deceased from MAY 22, 19 69, to MAY 30, 19 69, that (I) (we) last saw the deceased alive on MAY 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S. Paige Strong, M.D. DEGREE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED: 5-31-69	
22d. PHYSICIAN'S NAME (Type): S. PAIGE STRONG, M.D.	22e. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD. 21532		

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: JUNE 2, 1969	23c NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY	23d LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24 FUNERAL DIRECTOR: JOSEPH R. DURST,	ADDRESS: FROSTBURG, MD. 21532	25a REC'D BY REGISTRAR DATE: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

1

06226

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06219

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print): First: Sarah Middle: N. Last: Kenny

2a. DATE OF DEATH: Month: May Day: 25 Year: 1969

2b. HOUR: 6:30 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Oct. 16, 1881

6. AGE (In years last Birthday): 87 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (State or foreign country): Moscow MD.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Cumberland MD.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 402 Pulaski St.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: —

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 402 Pulaski Street

14. FATHER'S NAME: First: Simon Middle: Kenny Last:

15. MOTHER'S MAIDEN NAME: First: Margaret Middle: Cavanaugh Last:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Agnes Carroll Address: Cumberland MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b): Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clarence Vincent M.D. DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (Type): Clarence Vincent

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5/28/69

23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cem.

23d. LOCATION (City or Town) (County) (State): Frostburg Allegany MD

24. FUNERAL DIRECTOR: Lowe Stein Inc. ADDRESS: Cumb. MD.

25a. REC'D BY REGISTRAR (Date): MAY 28 1969

25b. REGISTRAR'S SIGNATURE: Thomas J. Hodge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A(15.4) 30M REV-1/68

06227

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06220

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: William	Middle: John	Last: Kinsman				2a DATE KNOWN OF DEATH ESTIMATED ☐	Month Day Year: May 3, 1969	2b HOUR: 12:30 p
3 SEX: Male	4. RACE: Cau.	5 DATE OF BIRTH: 8/13/26	6 AGE (In years last birthday): 42 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		2c DATE PRONOUNCED DEAD: Month Day Year: May 3, 1969		2d HOUR: 12:30p M.
7a. BIRTHPLACE (State or foreign country): Penna.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.						
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital--DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman	12b KIND OF BUSINESS OR INDUSTRY: Retail Store						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Box 150A Cash Valley Rd.					
14. FATHER'S NAME First: Harry	Middle: J.	Last: Kinsman	15. MOTHER'S MAIDEN NAME First: Katherine	Middle: A.	Last: Carey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes, give war or dates of service): W.W. #II	16b. SOCIAL SECURITY NO.: 220-16-6129	17. INFORMANT ADDRESS: Mrs. Audrey A. Kinsman Box 150A Cash Valley Rd.						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion — Approx. Interval Between Onset and Death: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — Approx. Interval Between Onset and Death: "

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 3, 1969

ADDRESS (Street, City, town, or County): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/6/69	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Md.	25a REC'D BY REGISTRAR DATE: MAY 7 1969	25b REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06228

CERTIFICATE OF DEATH

06221

1. DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
DANIEL	NMI	KLOTZ	MAY 23 69	10:45 M

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	WHITE	SEPT 7, 1883	85 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINORS HOSPITAL	RETIRED BLACKSMITH	METAL WORK

13a USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
MARYLAND	GARRETT	GRANTSVILLE		NONE

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
CHRISTIAN		KLOTZ	MARY		PEPE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO		RUTH NEWMAN	GRANTSVILLE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diffuse bilateral pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Candida & staphlyococcus organisms

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease — 6 weeks

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — 517.2

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute pulmonary infarct, left

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC	21f LOCATION Street or R F D No	City or Town	County	State

22a. I certify that (I) (~~this Hospital~~) attended the deceased from April 8, 19 69 to May 23, 19 69, that (I) (we) last saw the deceased alive on May 23, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
G. Paige Strong	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	May 24, 1969

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
A PAIGE STRONG	167 E MAIN ST. FROSTBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5/26/69	ST PAUL'S CEMETERY	ACCIDENT, GARRETT, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Ruth Newman	GRANTSVILLE, MD.	MAY 29 1969	[illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 5M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06222

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE OF DEATH KNOWN ☒ EST. ☐ Month Day Year	2b HOUR
JUANITA	OLIVE	KNIPPENBERG	May 13, 1969	4p M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year 19	2d HOUR
Female	White	Jan. 28, 1910	59 YRS			May 13, 1969	5p M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH	
Maryland	U. S. A.		Allegany	Md
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.)	12b KIND OF BUSINESS OR INDUSTRY	
Cumberland	6G Jane Frazier Villiage		Textile	
13a USUAL RESIDENCE (Where deceased l ved, f institut on Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER	
Maryland	Allegany	Cumberland	YES ☒ NO ☐	6G Jane Frazier Villiage	
14 FATHER S NAME First Middle Last		15. MOTHER S MAIDEN NAME First Middle Last	
William Everett Knippenberg		Louise C. Handle	
16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECUR TY NO	17 INFORMANT ADDRESS	
No	214-05-4533	Mrs. Irene Lashley Cumberland, Md.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gove nse to immediate couse (a), stating the underlying couse lost

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION G VEN IN PART I(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d N.JURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF .NJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No City or Town County State

22a I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED May 13, 1969

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

23a BUR AL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/16/69	Sunset Memorial Park	Cumberland, Allegany, Md.

24 FUNERA. DIRECTOR ADDRESS	25a. REC D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave., Cumb., Md.	DATMAY 16 1969	

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06230 — 06223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: EDGAR	Middle: W.	Last: LANCASTER	2a. DATE OF DEATH: Month MAY Day 19, Year 1969	2b. TIME: 3:00 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: AUGUST 13, 1904	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MAINTENANCE	12b. KIND OF BUSINESS OR INDUSTRY: CLARK CONTR.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 127 FROST AVENUE		
14. FATHER'S NAME First: HILARY	Middle	Last: LANCASTER	15. MOTHER'S MAIDEN NAME First: ELIZABETH	Middle: ELLEN	Last: RICHARDSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service): N.A.	16b. SOCIAL SECURITY NO.: 217-10-5593	17. INFORMANT: MRS. HENRY WEBER, 127 FROST AVE., FROSTBURG, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day -

DUE TO, OR AS A CONSEQUENCE OF (b): N C V D. — weeks.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 5/16, 1969, to 5/19, 1969, that (I) ~~(we)~~ last saw the deceased alive on 5/19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John B. Davis, M.D.	DEGREE	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED: 5/21/69.				
22d. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M.D.	22e. ADDRESS: 2 BROADWAY, FROSTBURG, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 5/22/69	23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME	ADDRESS: 60 W. MAIN, FROSTBURG	25a. REC'D BY REGISTRAR: MAY 26 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15
30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06231 — 06224

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
ETHEL	A.	LIGHT	05 07 69	4:45 M

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	09-23-83	85 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.		ALLEGANY COUNTY, Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL		

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER
MARYLAND		RAWLINGS,		RT. #3, BOX 46

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
PHILLIP		EDWARD	(BALLARD) ELIZABETH		

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	214-32-2906	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARCINOMA OF TAIL OF PANCREAS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

1578

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

BRONCH. ASTHMA EMPHYSEMA; ARTERIOSCLEROTIC HEART DIS.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from [illegible], 1946, to 5/7, 1969, that (I) (we) last saw the deceased alive on 5/6, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
S.G. Weisman	M.D.				5/7/69

22d PHYSICIAN'S (NAME (Type))	22e. ADDRESS
S.G. WEISMAN, M.D.	59 GREENE ST., CUMB., MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/10/69	Philos	Westernport Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
E.L. Beal BOAL'S FUNERAL HOME	111 CHURCH ST., WESTERNPORT	MAY 9 1969	[illegible] Judge

1

06232

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06225

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print): First: Rose; Middle: D.; Last: Loible

2a DATE OF DEATH: Month: May; Day: 18; Year: 1969

2b HOUR: 5:45 P.M.

3 SEX: Female

4 RACE: White

5 DATE OF BIRTH: 10/6/1885

6 AGE (In years last birthday): 83 YRS

If UNDER 1 YEAR: MONTHS / DAYS

If UNDER 24 HRS.: HOURS / MIN

7a BIRTHPLACE (State or foreign country): Maryland

7b CITIZEN OF WHAT COUNTRY?: U. S. A.

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Allegany County Md

10 CITY OR TOWN OF DEATH: Cumberland

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary

12a USUAL OCCUPATION (Kind of work done during most of working life even if retired): Retired:Reg. Nurse

12b. KIND OF BUSINESS OR INDUSTRY: R. N.

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland

13b COUNTY: Allegany

13c CITY OR TOWN: Cumberland

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET AND NUMBER: 302 Pulaski Street

14 FATHER'S NAME: First: John; Middle; Last: Drumm

15 MOTHER'S MAIDEN NAME: First: Priscilla; Middle; Last: Knippenberg

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b SOCIAL SECURITY NO: 215-36-8914A

17 INFORMANT: P.O.Box 599, Cumberland,Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROX. INTERVAL BETWEEN ONSET AND DEATH: appox. 3dy.

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Chr. ASHD: Hypertension - many years

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis - many years.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chr. Brain Syndrome. Left C.V.A. 6/68. P.V.D.

19a. DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐

21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION: Street or R.F.D. No. | City or Town | County | State

22a. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1968, to May 18, 1969, that (I) (we) last saw the deceased alive on May. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: John A Topper — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☒ STAFF PHYS ☒

22c DATE SIGNED: 5-19-69

22d PHYSICIAN'S NAME (Type): John A. Topper M.D.

22e ADDRESS: Memorial Hospital, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE: 5/21/69

23c NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24 FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. ADDRESS: 21502 Cumberland,Md

25a RECD BY REGISTRAR DATE: MAY 22 1969

25b REGISTRAR'S SIGNATURE:

VR A15 5M 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06233 — 06226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	BENJAMIN	Middle I.	Last MARX
2a. DATE OF DEATH Month Day Year	5 9 69		2b. HOUR 11:10 PM
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH	5-3-91		
6. AGE (In years last birthday)	78 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	LITHUANIA		
7b. CITIZEN OF WHAT COUNTRY?	U. S. A		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. COUNTY OF DEATH	ALLEGANY Md		
10. CITY OR TOWN OF DEATH	CUMBERLAND		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSPITAL		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	RETIRED		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	MARYLAND		
13b. COUNTY	ALLEGANY		
13c. CITY OR TOWN	CUMBERLAND		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	600 SHRIVER AVENUE		
14. FATHER'S NAME First	HERSHEL	Middle	Last MARX
15. MOTHER'S MAIDEN NAME First	SARAH	Middle	Last GOLDEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		If yes give war or dates of service	
16b. SOCIAL SECURITY NO.			
17. INFORMANT	MEMORIAL HOSPITAL	Address	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	Broncho Pneumonia bilateral	5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Ventricular Failure, right and left.	6 days
DUE TO OR AS A CONSEQUENCE OF (c)	Paroxysmal Auricular Fibrillation Coronary Arteriosclerosis, Myocardial Fibrosis,	Over 10 years

410 3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Uremia, Benign Hypertrophy of Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from May 4, 1969, to May [illegible], 1969, that (I) (we) last saw the deceased alive on May 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	[signature]	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED 5-10-69
22d. PHYSICIAN'S NAME (Type)	DR. S. JACOBSON	22e. ADDRESS	CUMBERLAND, MD.

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	5/11/69	East View Cem.	Cumberland Allegany MD	
24. FUNERAL DIRECTOR	Louis Stein Inc. Cumb. MD	ADDRESS	25a. RECD BY REGISTRAR DATE MAY 13 1969	25b. REGISTRAR'S SIGNATURE [signature]

VR A15 (Rev) 45M - 1-69

1

FOR STATE HEALTH DEPT.

06234

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06227

1. DECEASED-NAME (Type or Print)	First: HESTEL	Middle: PEARL	Last: MC KAY	2a. DATE KNOWN OF DEATH / ESTD. DEATH / MAILED: Month Day Year: MAY 11, 1969	2b. HOUR: 9 AM		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Aug. 13, 1897	6. AGE (in years last birthday): 71 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month Day Year 19: May 11, 1969	2d. HOUR: 3p M
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 902 Michigan Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): Registered Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 902 Michigan Ave.			
14. FATHER'S NAME First: Charles	Middle: Fox	Last: Twigg	15. MOTHER'S MAIDEN NAME First: Catherine	Middle: Goldsborough	Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: Cyril J. & Joseph K. Mc Kay, Sons	ADDRESS: Cumberland, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	----
DUE TO, OR AS A CONSEQUENCE OF (c)		

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
HYPERTENSIVE CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: MAY 11, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 14, 1969	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: MAY 13 1969	25b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

4/09

1

06235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
FRANK	N.	METZ	5 Month 23 Day 69 Year	5:07 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	WHITE	8/25/92	76 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
MARYLAND	USA	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life. If retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	MINER	MINER

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	BARTON	YES [X] NO [ ]	

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		METZ	AMY	POLAND	METZ

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
YES		215 10 4404	SACRED HEART HOSPITAL RECORDS	~~900 SETON DRIVE~~ CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Renal failure

492X

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Severe Pulmonary

DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one week

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Anemia - cause undetermined

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from 4-23-, 1969, to 5-23-, 1969, that (I) (we) last saw the deceased alive on 5-23- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Earl E. Paul		[X]	[ ]	[ ]	5-26-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. E. PAUL	414 N MECHANIC ST -CUMBERLAND, MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	5/26/69	Laurel Hill	Moscow Mills		Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
BOAL'S FUNERAL HOME Ed Boal	WESTERNPORT, MD. 21562	MAY 29 1969	Clarence Judge

VR AIS 10 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06236 06229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First: MARY	Middle: C.	Last: MICHAEL	2a. DATE OF DEATH Month: 5 Day: 30 Year: 69	2b. HOUR: 12:40 P.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 12-5-82 01	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: PENNA.	13b. COUNTY	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 1	
14. FATHER'S NAME First: ISRAEL	Middle	Last: GLOTFELTY	15. MOTHER'S MAIDEN NAME First: BARBARA	Middle	Last: WITZGALL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: 181-38-0119	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO OR AS A CONSEQUENCE OF
(b): Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 5-28-, 1969, to 5-30-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 5-30-1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death

22b. SIGNATURE: W. F. Williams DEGREE — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 5-31-69

22d. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/2/69	23c. NAME OF CEMETERY OR CREMATORY: Grantsville Cemetery	23d. LOCATION (City or Town) (County) (State): Grantsville, Garrett, Md.	
24. FUNERAL DIRECTOR: Ken Pearrow	ADDRESS: Grantsville, Md.	25a. RECD BY REGISTRAR DATE: JUN 5 1969	25b. REGISTRAR'S SIGNATURE: Roberta Judge	

VR A15 45M 1/69

1

FOR STATE HEALTH DEPT.

06237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06230

1 DECEASED NAME (Type or Print) First	Middle	Last
LUCILE	--	MILLER

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: May 19, 1969 — 2b. HOUR: 3:05 PM

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	If UNDER 1 YEAR: MONTHS / DAYS	If UNDER 24 HRS: HOURS / MIN.
Female	White	July 11, 1903	65 YRS		

2c. DATE PRONOUNCED DEAD Month Day Year: May 19, 1969 — 2d. HOUR: 3:05 PM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U. S. A.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland,	Memorial Hospital--DOA	Housewife,	Own home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES [X] NO [ ]	420 Fayette St.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank	L.	Bennett	Hattie	--	Routzhan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No,		Mrs., Joseph E. Strickland, Henry Dr. LaVale, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CRUSHED SKULL	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	(AUTO ACCIDENT)	
DUE TO, OR AS A CONSEQUENCE OF (c)		

8120

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR AM/PM	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	3:05 P PM May 19, 1969	Driver in two car crash

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State
	Rt. #40	Rt.#40 Near Flintstone, Allegany, Maryland

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: May 19, 1969

ADDRESS (Street, city, town, or RFD): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/22/69	Hillcrest Burial Park,	Cumberland, Allegany Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	MAY 26 1969	Wesley Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if no delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form P13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR ATSME 6
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

06238 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06231

1 DECEASED-NAME (Type or Print) First: Lena; Middle: ; Last: Morgan				2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: May 16 1969	2b HOUR: 4:30 P.M.
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: Sept. 12, 1887	6 AGE (In years last birthday): 81 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN	2c. DATE PRONOUNCED DEAD Month Day Year: May 16 1969	2d HOUR: 5:00 P.M.
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 301 E. Oldtown Rd.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY: Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 301 E. Oldtown Road	
14 FATHER'S NAME First: John; Middle: ; Last: Dicken		15 MOTHER'S MAIDEN NAME First: Jeannette; Middle: ; Last: Oster			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT: Daughter	ADDRESS: Mrs. Elsie Easton, Cumberland, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city town, or county): Rt. 9, Cumberland, Md.

22b DATE SIGNED: May 16, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 19, 1969	23c NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a RECD BY REGISTRAR DATE: MAY 21 1969	25b REGISTRAR'S SIGNATURE: [signature]	

1

06239

Item6 FilmG413 5/29/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (C) 30M REV 1968

1. DECEASED-NAME (Type or print) First: Martha; Middle: ; Last: Morris	2a. DATE OF DEATH Month: 5 Day: 12 Year: 69	2b. HOUR: 5:10 P. M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 1/29/90	6. AGE (In years last birthday): 78 79 YRS. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S, A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany, Cumberland, Md.
10. CITY OR TOWN OF DEATH: Cumberland, Maryland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Frostburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: Apt. 80 Frost Village			
14. FATHER'S NAME First: George; Middle: ; Last: Morris	15. MOTHER'S MAIDEN NAME First: Virginia; Middle: ; Last: Atkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-46-5256-T	17. INFORMANT: P. O. Box 599 Allegany County Infirmary Address: Cumberland, Records Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b): Gen. arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes / Gen.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from February 19 69, to May 12, 19 69, that (I) (we) last saw the deceased alive on May 12, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Simons M.D. DEGREE	ATTENDING PHYS ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒	22c. DATE SIGNED: 5/13/69	
22d. PHYSICIAN'S NAME (Type): George M. Simons	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 5-14-1969	23c. NAME OF CEMETERY OR CREMATORY: St. Michaels	23d. LOCATION (City or Town): Frostburg,	(County): Alleg. (State): Md.
24. FUNERAL DIRECTOR: Joseph R Durst	ADDRESS: Frostburg	25a. REC'D BY REGISTRAR DATE: MAY 19 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06240 — 06233

1. DECEASED-NAME (Type or Print)	First: RAYMOND	Middle: JESSE	Last: MOYERS	2a DATE KNOWN OF DEATH ESTIMATED ☐	Month: May	Day: 24	Year: '69
2b HOUR	3a M						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month	Day	Year
	MALE	WHITE	MAY 11, 1911	58 YRS			May 24	'69
2d. HOUR	4a M						
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH				
WEST VIRGINIA	U.S.A.		ALLEGANY Md				
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY				
FROSTBURG	CONSOL ST.	SALESMAN - FORD GARAGE					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
MARYLAND	ALLEGANY	FROSTBURG	YES ☐ NO ☒	CONSOL STREET			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last		
BERT	A.	MOYERS	MERTIE	E.	JUDY		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
YES		223-10-5163	MRS. MAXINE MOYERS	FROSTBURG, MD. 21532			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Hemorrhage in Bronchi — Approximate interval between onset and death: Minutes

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D No.	City or Town	County	State

22a. I **certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 24, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	MAY 26, 1969	MOYERS CEMETERY	FRANKLIN, W. VA.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	MAY 26 1969	Dorothy Judge

1

06241

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JAMES	L.	NIGHTENGALE	May	7	1969	M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	July 1st. 1898	70 YRS.				

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MD.	USA.		Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Retired Miner	Coal

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	YES ☒ NO ☐	Gills Hill

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	A.	Nightengale	Mary		Lyons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO			Mrs. Isabelle Nightengale (WIFE)	Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute pyelitis — 14 days

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Pul. Fibrosis Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) this hospital attended the deceased from _____, 19 59, to May 7, 19 69, that (I) (we) last saw the deceased alive on May 6 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
L.R. Miles Jr.					5-8-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
L.R. MILES, JR.	LONACONING, MD.

23a. BURIAL, CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 9th. 1969	Sunset Memorial Park,	Cumberland, Md.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
GEORGE EICHHORN Lonaconing, Md.	MAY 9 1969	Hilarius Juergen

VR A15 (4) 30M REV 68

06242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item6 Film G413 5/29/69 kk

06235

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV 68

1509

1. DECEASED-NAME (Type or print)	First: DONALD	Middle: M	Last: NORRIS	2a. DATE OF DEATH: 5 Month, 16 Day, 69 Year	2b. HOUR: 1:15 P.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: FEB.11.1917	6. AGE (In years last birthday): 51 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / M.M	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md			
10. CITY OR TOWN OF DEATH: RURAL LITTLE ORLEANS	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY: HOUSES			
13a. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) STATE: MD	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LITTLE ORLEANS	13d. INSIDE CITY LIMITS? YES [X] NO [X]	13e. STREET AND NUMBER		
14. FATHER'S NAME: First JOHN Middle Last NORRIS	15. MOTHER'S MAIDEN NAME: First MINNIE Middle B Last JEROME					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 220.10.4094	17. INFORMANT: SARAH B NORRIS Address: RURAL LITTLE ORLEANS MD				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes mellitus — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic alcoholism — 15 yrs.

(Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/17/69, 19____, to 5/16, 1969, that (I) (we) last saw the deceased alive on 5/13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
F B Thomas III M.D.	ATTENDING PHYS [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]		5/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
F B Thomas III M.D.	HANCOCK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
BURIAL	5,19.69	PINEYPLAINS	RURAL LITTLE ORLEANS MD		

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard L Gene Hancock md		MAY 21 1969	J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06243

06236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1579

1. DECEASED-NAME (Type or print) First: JOHN	Middle: FRANCIS	Last: O'SULLIVAN	2a. DATE OF DEATH Month: MAY Day: 18 Year: 1969
2b. HOUR P: 11:05 M	3 SEX: MALE	4 RACE: WHITE	5. DATE OF BIRTH: 10-04-17
6 AGE (In years last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): IRELAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CONTRACT ADMINISTRATOR	12b. KIND OF BUSINESS OR INDUSTRY: HERCULES IN
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 118 WINSLOW ST.			
14. FATHER'S NAME First: JOHN	Middle: J.	Last: O'SULLIVAN	15. MOTHER'S MAIDEN NAME First: (EGAN) CATHERINE	Middle	Last: O'SULLIVAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): WW 2	16b. SOCIAL SECURITY NO: 110-10-7051	17. INFORMANT: HOSPITAL RECORDS, 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARCINOMATOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

1579

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): CARCINOMA OF PANCREAS

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from SEPT, 1968, to 18 MAY, 1969, that (I) (~~we~~) last saw the deceased alive on 18 MAY 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: L. Glick	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 5-19-69	
22d. PHYSICIAN'S NAME (Type): L. MICHAEL DR. ~~SINGGLE~~ (BMG) Glick	22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/21/1969	23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens	23d. LOCATION (City or Town): Near Cumberland	(County): Alleg (State): Md.
24. FUNERAL DIRECTOR: HAFER FUNERAL HOME, LAVALE, MD. 21502 John J. Hafer, Jr., 1230 Baltimore Ave. ~~Cumberland~~	ADDRESS	25a. REC'D BY REGISTRAR DATE: MAY 22 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15
45M

1

06244

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: ELDON	Middle: D	Last: PAXTON	2a. DATE OF DEATH Month: MAY	Day: 3	Year: 1969	2b. HOUR: PM 3:05
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 6-16-02	6. AGE (In years last birthday): 66 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): CUMB. MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Service Station Operator	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: ROUTE 1, HOMEWOOD ADDN.			
14. FATHER'S NAME First: ELDON	Middle: O	Last: PAXTON	15. MOTHER'S MAIDEN NAME First: DATSY	Middle	Last: FRANTZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 214-05-7268	17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma Left Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1969 to May 3, 1969, that (I) (we) last saw the deceased alive on May 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: B. McSchindler	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 5-5-69			
22d. PHYSICIAN'S NAME (Type): DR. BLANE SCHINDLER	22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/6/69	23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: Cumberland, Md 21502	25a. RECD BY REG'STRAR DATE: MAY 8 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06245 — 06238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First / Middle / Last	ROBERT / TILGHMAN / POWELL	2a. DATE OF DEATH Month / Day / Year	5 / 8 / 69	2b. HOUR	1130 M A
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	JAN. 2, 1884
6. AGE (In years last birthday)	85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. COUNTY OF DEATH	ALLEGANY Md.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	CUMB. NURSING CENTER	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	OFFICER
12b. KIND OF BUSINESS OR INDUSTRY	BANK				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET AND NUMBER	1105 FREDERICK STREET		
14. FATHER'S NAME First / Middle / Last	ROBERT D. POWELL	15. MOTHER'S MAIDEN NAME First / Middle / Last	ELIZABETH GORE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	NO	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	214 07 1323
17. INFORMANT	MRS. ETHEL POWELL	Address	CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Cerebral vascular accident Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4-12-69

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Far advanced Arteriosclerotic Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Aging

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 8-9- 1966 to 5-8- 1969, that (I) (~~we~~) last saw the deceased alive on 4-27- 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE	W. L. Williams	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	5-9-69				
22d. PHYSICIAN'S NAME (Type)	W. F. WILLIAMS, M.D.	22e. ADDRESS	122 S. CENTRE ST. CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	MAY 11, 1969	HILLCREST BURIAL PARK	CUMBERLAND, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
BYRON KIGHT	CUMBERLAND, MD.	MAY 13 1969	[signature]	

VR A15 (4) 30M REV. 1-68

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06246 — 3239

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Annie; Middle: ; Last: Pryor	2a. DATE OF DEATH Month: May; Day: 1; Year: 1969 @ 11:10 A.M.	2b. HOUR A.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 7/4/1887	6. AGE (In years last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany County, Md
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 220 Humbird Street
14. FATHER'S NAME First: Morgan; Middle: ; Last: Burton		15. MOTHER'S MAIDEN NAME First: Rachael; Middle: Elizabeth; Last: Burton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: P.O. Box 599, Allegany County Infirmary records.	Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
+107
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Nov. 4, 1966, to May 1, 1969, that (I) (we) last saw the deceased alive on April 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Simon M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS ☒ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): George M. Simon — 22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 3, 1969	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. RECD BY REGISTRAR DATE: MAY 6 1969	25b. REGISTRAR'S SIGNATURE: Charles Yeager	

VR A-15 M 45M 1-69

Item13 FilmG413 5/29/69 1-6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06247 (typed) 06240 (printed)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form P.M.5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours, after death.

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED ☐ Month	Day	Year	2b HOUR
Vance	Vernon	Reip	5	14	1969	5 P M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.	2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
Male	White	Sept 9, 1910	58 YRS					5	14	1969	5 P M

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Penna	U.S.A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland Rt #3	DOA-Memorial Hospital	Owner & Operator of Reip Garage.	

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Penna Maryland	Bedford Allegany	Rt3 Cumberland	YES ☐ NO ☒	Rt #3

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		Reip	Elsie		Price

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	220-03-7723	Mrs. Mary Reip	Rt #3- Box 449 Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, m.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED May 14, 1969

ADDRESS (Street, city, town, or county) Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/17/69	Fishertown Pa Cemetery	Fishertown Bedford Penna

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	MAY 19 1969	

VR A15ME (5) 10M REV '68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06248 — 06241

1 DECEASED NAME (Type or print) First: ANDREW	Middle: J.	Last: RICE	2a DATE OF DEATH Month 05 Day 28 Year 69 — 2b HOUR 6:00 PM
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 07-14-96	6 AGE (In years last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY COUNTY, Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): SOUTH CUMB. PLANING MILL	12b KIND OF BUSINESS OR INDUSTRY: Lumber
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e STREET AND NUMBER: 30 Somerville AVENUE
14 FATHER'S NAME First: ~~HENRY~~ Stephen	Middle	Last: RICE	15 MOTHER'S MAIDEN NAME First: ?	Middle: SOPHIA	Last: Hout ~~RICE~~
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 214-05-8695	17 INFORMANT: SACRED HEART, SETON DR.,	Address: CUMB., MD. 21502

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) thrombosis of renal arteries — APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH: 36 hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) generalized arteriosclerosis, aortic thrombus — 2 years

DUE TO, OR AS A CONSEQUENCE OF

(c) Aortic Aneurysme

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION: 5-27-69	19b CONDITION FOR WHICH OPERATION WAS PERFORMED: aortic aneurysme	20a. AUTOPSY? YES ☒ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a I certify that (I) (this hospital) attended the deceased from 4-2-, 19 69, to 5-28-, 19 69, that (I) (we) last saw the deceased alive on 5-28- 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Leon Briggs M.D. — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐			22c DATE SIGNED: 5-30-69
22d. PHYSICIAN'S NAME (Type): L. BRIGGS, M.D.		22e. ADDRESS: 57 GREENE ST., CUMB., MD. 21502	

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 1, 1969	23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery	23d LOCATION (City or Town): Cumberland,	(County): Allegany,	(State): Md.
24 FUNERAL DIRECTOR: WENDT FUNERAL HOME, 121 MEMORIAL AVE., CUMB.,	ADDRESS: MD. 21502	25a REC'D BY REGISTRAR: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Wanda Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 7-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06249 06242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print): First CARL Middle EDWARD Last RICE
2a. DATE OF DEATH: MAY Month 22 Day 1969 Year
2b. HOUR: 4:00A
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 9-30-88
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MD.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Ma
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSP.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired B & O Carman
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: RT. 2 BALTIMORE PIKE
14. FATHER'S NAME First THEODORE Middle Last RICE
15. MOTHER'S MAIDEN NAME First IDA Middle M. Last PAXTON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 705-09-9627
17. INFORMANT: Juanita Wigfield Address: Rt #2 Balt Pike Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia - renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): for advanced carcinoma prostate
DUE TO, OR AS A CONSEQUENCE OF
(c): - metastases — 10 yrs +

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/19/, 1969, to 5/24/, 1969, that (I) (we) last saw the deceased alive on 5/23/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Walter N. Hemmler M.D. DEGREE — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 5/23/69
22d. PHYSICIAN'S NAME (Type): DR. HIMMLER
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5/25/69
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. ADDRESS: Cumberland, Md 21502
25a. RECD BY REGISTRAR DATE: MAY 26 1969
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR 45M 6-69

1

06250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ELSIE	Middle: L.	Last: ROBEY	2a. DATE OF DEATH: Month 5 Day 12 Year 69	2b. HOUR: 9:47 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 7-26-1887	6. AGE (in years last birthday): 81 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): None	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 240 MASSACHUSETTS AVE.,	
14. FATHER'S NAME First: DAVID	Middle	Last: CONRAD	15. MOTHER'S MAIDEN NAME First: Annie	Middle: Sullivan	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL-CUMBERLAND, MD.	Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Gangrene RLE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic Cardiovascular — 7

DUE TO, OR AS A CONSEQUENCE OF

(c): Disease — 6

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Arteriosclerotic heart disease

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 5/12, 1969, to 5/12, 1969, that (I) (we) last saw the deceased alive on 5/12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I), (we) (did) (did not) view the body after death

22b. SIGNATURE: I. Weisman	DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 5/13/69	
22d. PHYSICIAN'S NAME (Type): DR. I. WEISMAN	22e ADDRESS: 59 GREENE ST. CUMB. MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/15/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS: Philip B. Wendt 121 Memorial Ave., Cumb., Md.	25a. REC'D BY REGISTRAR DATE: MAY 16 1969	25b. REGISTRAR'S SIGNATURE		

VR A15 (X)
45M - 1/69 (X)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06251 — 06244

1. DECEASED NAME (Type or print)	First: FERN	Middle:	Last: ROMAN	2a. DATE OF DEATH Month: 5 Day: 20 Year: 69	2b. HOUR: 6:00A
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 4-24-1897	6. AGE (In years last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY COUNTY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY CO.	13c. CITY OR TOWN: CUMB.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 308 PENNA. AVE.	
14. FATHER'S NAME First / Middle / Last: Edward J. Rockwell		15. MOTHER'S MAIDEN NAME First / Middle / Last: Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 217-10-3134	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocarditis

DUE TO OR AS A CONSEQUENCE OF (c): Cerebral Vascular Insufficiency - Thrombosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular Disease.

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No / City or Town / County / State	

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 9/7, 1967, to May, 1969, that (I) (We) last saw the deceased alive on 5-19-69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~We~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 5-2-69	
22d. ~~PHYSICIAN'S~~ NAME (Type): DR. G. HIMMELWRIGHT	22e ADDRESS: 133 Virginia Ave., Cumberland, Md.		

23a. BURIAL CREMATION, REMOVAL (Specify): Removal	23b. DATE: May 20,1969	23c. NAME OF CEMETERY OR CREMATORY: Johns Hopkins Hospital For Research	23d. LOCATION (City or Town): Baltimore,	(County) (State): Md.
24. FUNERAL DIRECTOR: James F. Scarpelli,	ADDRESS: Cumberland, Md.	25a. RECD BY REGISTRAR DATE: MAY 23 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR Ar... 45M - ...

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 (give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

06252 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First: BENJAMIN Middle:	Last: ROSENBERG	2a DATE KNOWN OF DEATH ESTIMATED ☐ Month: MAY Day: 3, Year: 1969	2b HOUR 4a M			
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: MARCH 17, 1903	6 AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month: May Day: 3, Year: 1969	2d HOUR 4a M	
7a BIRTHPLACE (State or foreign country): NEW YORK	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md			
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED CLERK	12b KIND OF BUSINESS OR INDUSTRY: GROCERY			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: GARRETT	13c CITY OR TOWN: FROSTBURG	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: STAR ROUTE		
14 FATHER'S NAME First: ISADORE Middle:	Last: ROSENBERG	15. MOTHER'S MAIDEN NAME First: SARAH Middle:	Last: FINE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS: SAMUEL ROSENBERG, STAR ROUTE, FROSTBURG, MD.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Septicemia	days
DUE TO, OR AS A CONSEQUENCE OF (b)	Gangrene	2-3 Weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Inanition	Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 440 ?

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month Day, Year HOUR A.M P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 3, 1969

ADDRESS (Street, city, town, or county): RD 9, CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5-3-1969	ALLEGANY COUNTY CEMETERY	CUMBERLAND, MD.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	MAY 8 1969	Florence Goodge

VR A15ME (5) 10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06253

CERTIFICATE OF DEATH

06246

1. DECEASED-NAME (Type or print)	First: THERESA	Middle: M.	Last: RUNION	2a. DATE OF DEATH: MAY Month 21 Day 1969 Year	2b. HOUR: 1:37 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 03-19-88	6. AGE (In years last birthday): 81 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired):	12b. KIND OF BUSINESS OR INDUSTRY:		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 912 PIEDMONT AVE.	
14. FATHER'S NAME First: HENRY	Middle:	Last: ASH	15. MOTHER'S MAIDEN NAME First: SARAH	Middle: K.	Last: GROSS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address: MEMORIAL HOSP., CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebro - vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic - Cardiovascular

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Ormer	DEGREE	ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐	22c. DATE SIGNED: 5/24/69	
22d. PHYSICIAN'S NAME (Type): DR. VAN ORMER	22e. ADDRESS: CUMBERLAND, MD.			

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 24, 1969	23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery	23d. LOCATION (City or Town): Fort Ashby, W. Va.	(County) / (State)
24. FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME.	ADDRESS: CUMB. MD.	25a. REC'D BY REGISTRAR DATE: MAY 27 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06254 — 06247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4) 45M 7/69

1. DECEASED NAME (Type or print)	First: ROBERT	Middle: J.	Last: RYAN
2a. DATE OF DEATH	Month: MAY	Day: 20	Year: 1969
2b. HOUR	M		
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH	JAN. 26, 1907		
6. AGE (In years last birthday)	62 YRS	If under 1 year: Months / Days	If under 24 hrs: Hours / Min
7a. BIRTHPLACE (State or foreign country)	MARYLAND		
7b. CITIZEN OF WHAT COUNTRY?	ALLEGANY		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	ALLEGANY Md		
10. CITY OR TOWN OF DEATH	CUMBERLAND		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	PIPE FITTER		
12b. KIND OF BUSINESS OR INDUSTRY	CELANESE		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	MARYLAND		
13b. COUNTY	ALLEGANY		
13c. CITY OR TOWN	ECKHART		
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]			
13e. STREET AND NUMBER			
14. FATHER'S NAME	First: GEORGE	Middle: R.	Last: RYAN
15. MOTHER'S MAIDEN NAME	First: MARINDA	Middle:	Last: PORTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	NO		
16b. SOCIAL SECURITY NO	213-09-6514		
17. INFORMANT	MRS. MARGARET RYAN, ECKHART, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic brain tumor — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Primary cancer left lung — 3 months

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
8/15/68	Cancer left lower lung	YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County / State

22a. I **certify** that (I) (this hospital) attended the deceased from May 3, 19 69 to May 20, 19 69 that (I) (we) last saw the deceased alive on May 20 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	G. Paige Strong	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)	A. PAIGE STRONG, M. D.	22e. ADDRESS	E. MAIN ST., FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	MAY 23, 1969	ECKHART CEMETERY	ECKHART, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
JOSEPH R. DURST, FROSTBURG, MD. 21532		DATE MAY 26 1969	J. Charles Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4/61X

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06255

CERTIFICATE OF DEATH

06248

1 DECEASED-NAME (Type or print) First / Middle / Last	IRMA H. SCHLOSSSTEIN	2a. DATE OF DEATH Month Day Year	MAY 15, 1969
2b. HOUR	8:45 M		
3 SEX	FEMALE	4. RACE	WHITE
5 DATE OF BIRTH	JULY 15, 1899	6 AGE (In years last birthday)	69 YRS
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a BIRTHPLACE (State or foreign country)	MASSACHUSSETTS	7b CITIZEN OF WHAT COUNTRY?	U.S.A.
8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	ALLEGANY Md.
10 CITY OR TOWN OF DEATH	FROSTBURG	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MINERS HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	OWNER APT. HOUSE	12b. KIND OF BUSINESS OR INDUSTRY	OWN BUS.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY
13c CITY OR TOWN	FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	120 GRANT STREET		
14. FATHER'S NAME First / Middle / Last	CARL E. SCHLOSSSTEIN	15. MOTHER'S MAIDEN NAME First / Middle / Last	MAGDALENA BORGER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	NO	(If yes give war or dates of service)	N.A.
16b SOCIAL SECURITY NO.		17 INFORMANT Address	MRS. LOUISE HACKETT, 440 BLUE ROAD, CORAL GABLES, FLA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Brain Syndrome

DUE TO, OR AS A CONSEQUENCE OF (b) Circulatory Disturbance

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Vascular Disease

401X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 16 hrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from MAY 14, 1969 to MAY 15, 1969, that (I) (we) last saw the deceased alive on MAY 14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	G. Paige Strong	DEGREE ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: May 15, 1969
22d. PHYSICIAN'S NAME (Type)	A. PAIGE STRONG, M.D.	22e ADDRESS	167 E. MAIN ST, FROSTBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)	
BURIAL	MAY 19, 1969	SUNSET MEMORIAL PARK	NORTH OLMSTEAD	OHIO
24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
HAFER-SOWERS FUNERAL HOME, Daniel M. Sowers	60 W. MAIN ST., FROSTBURG, MD.	MAY 21 1969	Clinton Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06256 06249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First: SYLVIA	Middle: R	Last: SCHWAB	2a DATE OF DEATH: Month 5 Day 28 Year 69	2b HOUR: 1:30P M
3 SEX: FEMALE	4. RACE: WHITE	5 DATE OF BIRTH: 8-20-94	6 AGE (In years last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 640 WASHINGTON ST.	
14. FATHER'S NAME First: LOUIS	Middle	Last: ROSENBAUM	15 MOTHER'S MAIDEN NAME First: ROSE	Middle	Last: PRICE
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Hypostatic Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Chronic Lymphatic Leukemia Nov. 68 — Nov.'68

DUE TO, OR AS A CONSEQUENCE OF

(c) [illegible] — [illegible]

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Thrombocytopenic purpura hemorrhagica

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Nov., 19 68, to May 28, 19 69, that (I) (we) last saw the deceased alive on May 28, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE [signature] DEGREE: ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED: May 29, 1969

22d PHYSICIAN'S NAME (Type): DR. SAMUEL JACOBSON — 22e ADDRESS: CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/30/69	23c NAME OF CEMETERY OR CREMATORY: East View Cem.	23d LOCATION (City or Town) (County) (State): Cumberland Allegany Md.	
24 FUNERAL DIRECTOR: Louis Stein Inc.	ADDRESS: Cumb. Md.	25a REG'D BY REGISTRAR DATE: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Charles [illegible]	

VR A15 45M 1-69

1

06257

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Mary	Middle: Jane	Last: Shade	2a. DATE OF DEATH: Month May Day 12 1969 — 2b. HOUR: 9:50 AM
3 SEX: Female	4 RACE: White	5. DATE OF BIRTH: July 24, 1894	6. AGE (In years last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.C.A. Memorial Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Papper Sorter	12b KIND OF BUSINESS OR INDUSTRY: Paper Mill
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Westernport	13d INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e STREET AND NUMBER: 112 Walnut
14 FATHER'S NAME First: Andrew	Middle: W. Michael	Last:	15. MOTHER'S MAIDEN NAME First: Laura	Middle: P.	Last: Broadwater
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 217-05-0387	17 INFORMANT: Dorothy Upperco	Address: Bel Air, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary sclerosis — 1 yr

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart disease — 5 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (the hospital) attended the deceased from 1962, 19___, to 10 May, 19 69, that (I) (we) last saw the deceased alive on 10 May 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Norman Reeves Jr M D — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 5/13/69

22d. PHYSICIAN'S NAME (Type): J. Norman Reeves M D — 22e. ADDRESS: Westernport, Md. 21562

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/15/69	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d LOCATION (City or Town): Westernport,	(County): Alle. (State): Md.
24. FUNERAL DIRECTOR: E. Bral	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: MAY 19 1969	25b. REGISTRAR'S SIGNATURE: Kenneth Fridge	

VR A15 (4) 30M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258 — 06251

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b HOUR
Casper	A.	Shook	☒ / ☐	May		19 69	6:10 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
Male	White	June 30, 1906	62 YRS					May	20	19 69	6:10 A M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARITAL STATUS	9 COUNTY OF DEATH
W. Va.	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Driver	Motor Lines

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	515 White Ave.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Baxter	A.	Shook	Virginia		Belle

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No		Paul A. Shook, Cumberland, Md.-Son

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Rt.9 Cumberland

22b DATE SIGNED May 20, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 22, 1969	Hillcrest Burial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	MAY 28 1969	Charles Judge

1 3 06259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Raymond	John	Smith	May 5, 1969	5 P.M.

3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	Oct. 15, 1898	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	U. S. A.		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Frostburg,	Miners Hosp.	Ret. Army Sgt.	U.S. Gov't

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Mt. Savage	YES ☐ NO ☒	Mile Lane Box 623

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	Jacob	Smith	Annie	Mary	Lowery

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes. W. W. I & 2		Harry J. Smith Box 623 Mt. Savage, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiovascular Decompensation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b) H c v D. — years

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes M - uncontrolled — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 250.9

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 5/2, 19 69, to 5/5, 19 69, that (I) (~~me~~) last saw the deceased alive on 5/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John B. Davis,					5/6/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John B. Davis, M.D.	2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/8/69	Hillcrest Burial Park.	Cumberland Allegany Md.

24 FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md.	MAY 12 1969	Charles Judge

VR A15 (4-30M REV. 1-68)

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible] Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

06260

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06253

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	2b HOUR
Anna	Rebecca	Spitzer	May 15, 1969	2 a M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	25 Feb 1916	53 YRS			May 15, 1969	7a M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
West Virginia	U.S.A.	MARRIED X	Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	725 Kelly Road	Housewife	Home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md	Allegany	Cumberland	YES X NO	725 Kelly Road

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	A.	Lewis	Elizabeth		Rumer

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No		Samuel Spitzer	Knoxville, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY OCCLUSION, RIGHT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 4104

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS — "

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS — ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES X

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. — M.D.

BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: MAY 15, 1969

ADDRESS (Street, city, town, or county) Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	17 May 1969	Queens Point	Keyser Mineal W.Va.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Allen M. Rotruck	Keyser, W.Va.	MAY 19 1969	

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06254

1. DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	2b HOUR
JOHN	B.	STEIDING	X MAY 24, 1969	6:00p M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	2/12/1912	57 YRS					MAY 24, 1969	6:00p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED X NEVER MARRIED WIDOWED DIVORCED	9 COUNTY OF DEATH
MD.	USA.		Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL-DOA	Consultant-Marietta, Co.	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	Allegany	Midland	YES X NO	Railroad St.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Earl		Steiding	Marion		Peebles

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No			Virginia Steiding (WIFE)	Midland, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY THROMBOSIS	"
DUE TO, OR AS A CONSEQUENCE OF (c)	CORONARY SCLEROSIS	-----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES XX NO

21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy XX, Inspection X, Inquiry X, and in my opinion death resulted from. Natural causes X, Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED May 24, 1969

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/27/1969	Elk Garden Cemetery	Elk Garden, Wva.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	MAY 27 1969	Charles Yeager

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

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06262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06255

1 DECEASED NAME (Type or Print)	First: WILBERT	Middle: ALBERT	Last: STEVENSON	2a DATE KNOWN OF DEATH [X] ESTIMATED [ ]	Month Day Year: MAY 4, 1969	2b HOUR: 10:55 PM			
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: AUG. 21, 1917	6 AGE (In years last birthday): 51 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: May 4, 1969	2d HOUR: 10:55 PM		
7a BIRTHPLACE (State or foreign country): MIDLAND, MD.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.						
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: FROSTBURG, MD. GUNTER HOTEL, W. MAIN ST.					
14. FATHER'S NAME First: ALBERT	Middle:	Last: STEVENSON	15. MOTHER'S MAIDEN NAME First: SARAH	Middle:	Last: SHEARER				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): W. WAR II	16b SOCIAL SECURITY NO: 217-03-0738	17 INFORMANT: FROSTBURG, MD. MRS. WILBERT A. STEVENSON, GUNTER HOTEL,						

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Crushed Chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): (Farm tractor accident)k

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
XXXX	9:15 PM May 4, 19 69	Farm tractor accident (ran over hill)		
21d INJURY OCCURRED WHILE AT WORK [XX] NOT WHILE AT WORK [ ]	**21e PLACE OF INJURY** (At home, farm, street, factory, office building, etc.) Farm	**21f LOCATION** Street or R.F.D No. Rt.#46, near Fort Ashby,	City or Town mineral,	State W.Va.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [XX] and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b DATE SIGNED: May 4, 1969

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5/8/69	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
MARILOU M. SOWERS, Marilou M. Sowers	HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	MAY 12 1969	

VR A15ME (5)
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06263

CERTIFICATE OF DEATH

06256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rockville Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Rockville Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: William; Last: Stewart

4. DATE OF DEATH: Month: May; Day: 3; Year: 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1885

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Company

11. BIRTHPLACE (County & State, or foreign country): Pekin, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hugh C. Stewart, Sr.

14. MOTHER'S MAIDEN NAME: Annie Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOC. SECURITY NO: 216-05-5729

17. INFORMANT: Hugh C. Stewart Address: Piedmont, W. Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO (b): Arteriosclerotic Heart Disease — 4 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 5, 19 61, to May 3, 19 69, that (I) (we) last saw the deceased alive on May 3, 19 69, and that death occured at 11:P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 5, 1969

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.

22d. ADDRESS: 111 Ashfield St. Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6, 1969

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

23d. LOCATION (City, town or county): Moscow (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Harold Endlich

ADDRESS: Piedmont, W. Va.

25a. REC'D BY REGISTRAR DATE: MAY 7 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06264 06257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 DECEASED-NAME (Type or print)	First: SIDNEY	Middle: H	Last: STORER	2a DATE OF DEATH Month: MAY	Day: 13	Year: 1969	2b HOUR 5:05 PM
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 8-8-88	6 AGE (In years last birthday): 80 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): CUMB. MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md				
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Machinist	12b KIND OF BUSINESS OR INDUSTRY: Textile				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 28 GRAND AVE.,			
14. FATHER'S NAME First: JAMES	Middle	Last: STORER	15 MOTHER'S MAIDEN NAME First: MARY	Middle: ANN	Last: CLARKE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address			

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Massive Mesenteric Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO, OR AS A CONSEQUENCE OF
(b) Thrombosis of the Deseending Aorta
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arteriosclerotic Cardiovascular disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Adams-Stoke Syndrome--Complete Heart Block

19a. DATE OF OPERATION: 5-7-69	19b CONDITION FOR WHICH OPERATION WAS PERFORMED: Implt. Permn. Pace*Maker	20a. AUTOPSY? YES [X] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 1959, 19 __, to May, 19 69, that (I) (~~last~~) saw the deceased alive on May 13,1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS [ ]	22c DATE SIGNED: May 15,1969
22d. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT	22e. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.			

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b. DATE: 5-16-1969	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a RECD BY REGISTRAR DATE: MAY 19 1969	25b REGISTRAR'S SIGNATURE

VR A15
45M 1 68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3.
5 may be retained for your files.
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VR A15ME (5)
10M REV 1/68

06265

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

1 DECEASED NAME (Type or Print) First: George	Middle: Roy	Last: Sturtz	2a DATE KNOWN OF ESTIMATED DEATH: ☐ ☐ Month: May	Day: 1	Year: 1969	2b HOUR: 6:[illegible]					
3. SEX: [illegible]	4. RACE: White	5. DATE OF BIRTH: Mar. 1, 1[illegible]	6 AGE (In years last birthday): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year 19				2d HOUR: [illegible]	
7a. BIRTHPLACE (State or foreign country): All Eglie, Md. USA	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany			Md					
10. CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital, Virginia Ave.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Supt.	12b. KIND OF BUSINESS OR INDUSTRY: Textiles								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: All[illegible]	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER							
14. FATHER'S NAME First: George	Middle	Last: Sturtz	15. MOTHER'S MAIDEN NAME First: Martha	Middle	Last: Devore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 21[illegible]-52[illegible]	17 INFORMANT: Mrs. George E. [illegible]	ADDRESS: [illegible]							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE PULMONARY EDEMA	2[illegible] Hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Left Myocardial Infarction, large	old
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Sclerosis with occlusion	--

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 120

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Pulmonary Emphysema, bilateral; Marked

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b DATE SIGNED: May 1, 1969
ADDRESS (Street, city, town, or county): [illegible], MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 4, 19[illegible]	[illegible]rest Cemetery	[illegible], Allegany, [illegible]

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
[illegible]	[illegible], Hyndman, Pa. 15545	MAY 5 1969	Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06266 — 06259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	JAMES W. VAN METER	2a. DATE OF DEATH Month / Day / Year	5 / 29 / 69	2b. HOUR	4:55 M
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	11/24/03
6. AGE (In years last birthday)	65 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	
9. COUNTY OF DEATH	ALLEGANY Md.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	TEXTILE
12b. KIND OF BUSINESS OR INDUSTRY	TEXTILE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND
13d. INSIDE CITY LIMITS?	YES X NO ☐	13e. STREET AND NUMBER	112 SHAW PLACE		
14. FATHER'S NAME First / Middle / Last	ISAAC L. VAN METER	15. MOTHER'S MAIDEN NAME First / Middle / Last	ANNA M. MC KENZIE VAN METER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown)	NO	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	214 07 4623
17. INFORMANT	HOSPITAL RECORDS	Address	~~900 SETON DRIVE~~ CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) pulmonary embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO, OR AS A CONSEQUENCE OF

(b) coronary sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c) generalized arteriosclerosis — 1 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 5-23-, 19 69, to 5-29-, 19 69, that (I) (we) last saw the deceased alive on 5-29- 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	L. Brings MD	DEGREE	ATTENDING PHYS ☑ / MED DIRECTOR ☐ / STAFF PHYS ☐	22c. DATE SIGNED	5-30-69
22d. PHYSICIAN'S NAME (Type)	DR. L. BRINGS	22e. ADDRESS	57 GREENE ST -CUMBERLAND, MARYLAND 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	6/2/69	Sunset Memo Pk.	Cumberland Allegany MD	
24. FUNERAL DIRECTOR	ADDRESS	25a. ACCEPTED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
LOUIS STEIN, INC.	117 FREDERICK STREET CUMBERLAND, MARYLAND 21502	JUN 3 1969	Charles Judge	

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06267 06260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year / 2b. HOUR
John	E.	Warnick	5	18	69 / M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	4/3/1879	90 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md	U.S.A.		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md	Allegany	Lonaconing	X	Jackson Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry	Harrison	Warnick	Mary		Dawson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		Mrs. Francis Warnick "Wife"	Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Uremia
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Urinary Tract Infection — 2 wks.
DUE TO, OR AS A CONSEQUENCE OF
(c)

5770
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from MAY 17, 1969, to MAY 18 1969, that (I) (we) last saw the deceased alive on MAY 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
G. Paige Strong, M.D.					May 19, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	5/21/69	Frostburg Memorial Park	Frostburg	A.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	MAY 21 1969	Charles Judge

VR AIE 21
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06268 06261

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Olive	M.	Wilderman	May 28, 1969	9:25 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	3/11/1900	69 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U. S. A.		Allegany County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Housekeeper	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Allegany	Frostburg		55 Frost Village

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward		Jordan	Mary		Lyons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
	220-10-1501T	P.O.Box 599, Allegany County Infirmary records.	Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — Approximate interval between onset and death: 1 dy.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chr. A.S.H.D. — many years

DUE TO, OR AS A CONSEQUENCE OF (c) Arteria-Sclerosis — many years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes Mellitus. C.V.A 2/68 Chr. Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Oct. 30, 1968, to May 28, 1969, that (I) (we) last saw the deceased alive on May 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☒	STAFF PHYS. ☒	22c. DATE SIGNED
John A Topper	MD				6-2-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A Topper MD	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	MAY 31, 1969	ST. MICHAEL'S CEMETERY	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JUN 3 1969	Peter Junge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06269 — 06262

1 DECEASED NAME (Type or Print)	First: William	Middle: P.	Last: Wilson	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: 5	Day: 15	Year: 1969	2b HOUR: 2.A M	
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: 8/19/1902	6 AGE (In years last birthday): 66 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 5 Day 15 1969		2d HOUR: 2A M	
7a BIRTHPLACE (State or foreign country): MD.	7b CITIZEN OF WHAT COUNTRY?: USA.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md						
10. CITY OR TOWN OF DEATH: Frostburg	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miners Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life. Never retired): Retired Miner	12b KIND OF BUSINESS OR INDUSTRY: Coal						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: Florida Way					
14. FATHER'S NAME First: Thomas	Middle:	Last: Wilson	15 MOTHER'S MAIDEN NAME First: Margaret	Middle:	Last: Pollock				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: Mrs. Viola Wilson, (WIFE)	ADDRESS: Lonaconing, Md.					

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): PULMONARY EMBOLISM — APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH: HOURS

8 50 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): FRACTURE OF RIGHT HIP — 8 Days

DUE TO, OR AS A CONSEQUENCE OF (c): (Fell down stairs)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [ ]	
21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. 1,45 P.M. May 7 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Fell down steps at home	
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f LOCATION Street or R.F.D. No.: Florida Way,	City or Town: Lonaconing,	County: Alleg.	State: Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: 5/15/1969

EXAMINER'S NAME (Type): Benedict Skitarelic — ADDRESS (Street and No., or Town, or City): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/17/1969	23c NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery	23d LOCATION (City or Town) (County) (State): Lonaconing, Md.	
24 FUNERAL DIRECTOR: George Eichhorn,	ADDRESS: Lonaconing, Md.	25a REC'D BY REGISTRAR DATE: MAY 19 1969	25b REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06270 — 06263

1. DECEASED-NAME (Type or print): First EARL; Middle L.; Last WRIGHT
2a. DATE OF DEATH: MAY Month 17 Day 1969 Year
2b. HOUR: 11:30 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: APRIL 10, 1896
6. AGE (In years last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: FROSTBURG
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FINISHING DEPT. - KS TIRE COMPANY
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: FROSTBURG
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 89 MT. PLEASANT ST.
14. FATHER'S NAME First JOHN; Middle; Last WRIGHT
15. MOTHER'S MAIDEN NAME First ANNIE; Middle; Last SEIFARTH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES (If yes give war or dates of service): WW 1
16b. SOCIAL SECURITY NO.: 212-10-7497
17. INFORMANT Address: MRS. EDITH WRIGHT, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Hypertension
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterio - sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Psychoneuroses

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4000

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Benign Hypertrophy of the prostate

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 3-19, 1969, to 5-17, 1969, that (I) (~~we~~) last saw the deceased alive on 5-17 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: H. C. Diehl M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 5/20/69
22d. PHYSICIAN'S NAME (Type): H. C. DIEHL, M. D.
22e. ADDRESS: 39 W. MAIN ST., FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: MAY 20, 1969
23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.
24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, FROSTBURG, MD. 21532
25a. REC'D BY REGISTRAR DATE: MAY 22 1969
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 14M 45M - 1-69

06271

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06264

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
HARRY	M.	WRIGHT	MAY 19 1969	9:10PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	07-21-04	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Retired Postmaster	POST OFFICE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.		WILEY FORD	YES [ ] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DAVID	W.	WRIGHT	(KELLY)	DELCIA	WRIGHT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	706-09-3685	HOSPITAL RECORD 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Esophagus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Calvin Y. Hadidian	M.D.	[X]	[ ]	[ ]	5/20/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
CALVIN Y. HADIDIAN, M.D.	203 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 22, 1969	Queens Point Cemetery	Keyser, W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli SCARPELLI FUNERAL HOME, CUMB., MD.	MAY 28 1969	Wilmer Judge

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VR A15 (4) 45M - 1/69